POC accepted 10/21/09 JC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED Wyoming Dept of Health OCT 13 2009 Office of Healthcare Licensing and Surveys

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A051	A. BUILDING _____ B. WING _____	09/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

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F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to make available to the residents, staff and the public the most recent health survey results of the facility. The findings were: Observation on 9/14/09 at 4:48 PM revealed a sign on the nurses' desk stating "State survey results". However, the notebook containing the results was not found on the desk. Interview with the director of operations at that time revealed the notebook was in a closed door cabinet behind the nurses' counter and had "probably been put there by housekeeping". Observation on 9/15/09 at 3:55 PM revealed the notebook was on the nurses' counter and available for review. However, review of the notebook revealed the most recent survey results were from 2007. Interview with clinical supervisor #1 at that time revealed the 2008 survey results were still in a file in the nursing office.	F 167	The facility will ensure the results of the most recent survey are available for examination and must post in a place readily accessible to residents and must post a notice of their availability. 1) The facility will post the most recent survey results in a binder placed on the nurses' station desk at all times. 09/15/09 2) A notice of the availability of the survey results will be posted on the nurses' station desk at all times. 09/15/09 3) The clinical supervisor will observe daily to ensure the survey results are on the nurses' station desk. 11/01/09 4) A quality monitoring tool will be implemented to ensure survey results are posted on the nurses' station desk. This will be reported at the QA/QI monthly meeting and at the medical director meeting.	11/01/09
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written	F 226	The facility must develop and implement written policies and procedures that prohibit	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 10/7/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation. Changes made per phone with Lourann Carmichael, Director of operations on 10/21/09 @ 3:05 PM. Janelle Cox, ONPL

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F 226	Continued From page 1 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on policy review, staff interview, and review of facility abuse investigations, the facility failed to develop a policy to ensure all allegations of abuse were reported to the Office of Healthcare Licensing and Surveys (OHLS) and the Department of Family Services (DFS) or law enforcement immediately. The findings were: 1. Review of the facility's policy and procedure "Abuse Prohibition" (revised June 3, 2009) revealed "...Alleged violations will be reported to the Office of Healthcare Licensing and Surveys." However, the policy did not state the allegations would be reported immediately. On 9/16/09 the facility's documentation of abuse investigations were reviewed. The review showed one allegation of verbal abuse by a staff member occurred on 4/12/09, but was not reported to the Office of Healthcare Licensing and Surveys until 4/20/09. During an interview on 9/16/09 at 10:32 AM, both clinical supervisors stated the allegation was not reported within 24 hours, as required. 2. Further review of the facility's "Abuse Prohibition" policy showed it did not include a requirement that DFS or law enforcement would be notified immediately of allegations of abuse. Review of facility documentation for two allegations of abuse showed DFS or law enforcement were not notified in either allegation. During an interview on 9/16/09 at 10:32 AM, both clinical supervisors confirmed DFS or law	F 226	mistreatment, neglect, and abuse of residents and missappropriation of resident property. 1) The facility's policy and procedure on abuse prohibition will be revised to state that allegations of abuse will be reported to the Office of Healthcare Licensing and Surveys and the Department of Family Services within 24 hours of the allegation. 10/08/09 2) At staff meeting on 09/30/09 staff members were instructed to contact clinical supervisors immediately regarding abuse allegations. 09/30/09 2) A quality monitoring tool will be implemented to ensure the abuse prohibition policy is revised and then reviewed yearly. 11/01/09 3) This will be reported monthly at the QA/QI meeting and at the monthly medical director meeting.	11/01/09

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F 226	Continued From page 2 enforcement were not notified. They stated they would only report substantiated abuse. They were unaware they needed to report allegations. According to Wyoming's Adult Protective Services Act, 35-20-103, "...Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited, or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the Department of Family Services."	F 226		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure dignity was maintained for 1 of 9 sample residents (#9). The findings were: 1. Observation during meals on 9/14/09 at 5:40 PM, 9/15/09 at 12:20 PM, and on 9/16/09 at 9:30 AM revealed resident #9 was seated in a geri-chair (wheeled reclining chair) in the hallway outside of the dining room by himself/herself. Review of the 6/11/09 nutritional assessment showed the resident ate in the main dining room at that time. The following concerns were identified: a. During an interview on 9/16/09 at 1:45 PM, the resident stated s/he broke a hip and was now using the geri-chair (medical record review showed the resident broke a hip on 9/1/09). The	F 241	The facility must promote care for residents in a manner and in an environment that maintains or enhances each residents' dignity and respect in full recognition of his or her individuality. 1) The clinical supervisor will observe meal times and ensure resident #9 is in the dining room for meals.and positioned so she can visit with tablemates. 11/01/09 2) Should the clinical supervisor note that resident #9 is not in the dining room or positioned so that she can visit with table-mates, the clinical supervisor will provide immediate instruction and corrective action to the CNA's and the charge nurse. 11/01/09 3)A quality monitoring tool will be implemented to ensure resident #9 is not isolated from the dining room and her tablemates during meals. 11/01/09 4) This will be reported at the QA/QI and medical director meeting.	

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F 241	Continued From page 3 resident stated there wasn't enough room in the dining room for the geri-chair. The resident further stated s/he used to sit in the dining room, and liked it, because s/he liked to talk to people. b. During an interview on 9/16/09 at 2:30 PM, registered nurse (RN) #1 stated the resident no longer ate in the dining room because she was afraid the resident would get bumped while seated in the geri-chair, since there wasn't enough room. The RN stated usually a staff person sat with the resident and ate with her. However, observation during the meals on 9/14/09, 9/15/09 and 9/16/09 revealed no staff sat with the resident. c. On 9/17/09 at 8:26 AM (after the concern was brought up to facility staff), observation revealed there was enough room in the dining room for the resident in the geri-chair. 2. Review of the 9/4/09 Minimum Data Set (MDS) assessment showed resident #9 utilized an indwelling urinary catheter. Observation on 9/14/09 at 5:40 PM and on 9/15/09 at 12:20 PM revealed the resident was seated in a public area (outside the dining room). The catheter bag was uncovered, and urine was visible in the bag and in the tubing.	F 241	5) At staff meeting on 09/30/09 staff members were instructed to make sure resident #9 eats in the dining room and that her catheter bag is covered at all times. 09/30/09 6) Catheter off resident #9 was discontinued. 09/16/09 7) Charge Nurses will observe that catheter bags are covered at all times. If they aren't covered, they will instruct the aides to cover the catheter bags. 11/01/09 8) A quality monitoring tool will be implemented to ensure catheter bags are covered at all times. 8) This will be reported monthly at the QA/QI meeting and medical director meeting. 1	11/01/09
F 272 SS=F	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must	F 272	The facility must conduct initially and periodically a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity. 1) The facility will make a comprehensive assessment of residents needs using the RAI specified by the state. It will include identification and demographic information, customary routine, dognitive	

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F 272	Continued From page 4 include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed in a variety of areas for 10 of 10 sample residents (#1, #4, #5, #6, #7, #9, #15, #18, #20, #23). The findings were: According to the Revised Long-Term Care Facility Resident Assessment Instrument [RAI] User's Manual, version 2.0, revised December 2008, page 4-5 "...Facility staff use the RAI triggering mechanism to determine which RAP [Resident Assessment Protocol] problem areas require review and additional assessment...RAP	F 272	patterns, communication, vision, mood and behavior patterns, psychosocial well being, physical functioning and structural problems, continence, disease diagnosis and health conditions, dental and nutritional status, skin conditions, activity pursuit, medications, special treatments and procedures, discharge potential, documentation of summary information regarding the additional assessment performed through the resident assessment protocols, and documentation of participation in assessment. 11/01/09 2) The Director of Operations will counsel with MDS Coordinator regarding timely completion of RAI/RAPS. 11/01/09 3) The MDS Coordinator has completed RAPS for residents #1, #4, #6, #7, #9. 10/07/09 4) The MDS Coordinator will complete RAPS for residents #5, #15, #18, #20. 11/01/09 5) The MDS Coordinator will be given uninterrupted time to complete her MDS assessment process. 11/01/09 6) The Director of Operations will monitor the MDS to ensure RAI/RAPS are completed and current. 11/01/09 7) A quality monitoring tool will be implemented to monitor RAI/RAPS for residents #1, #4, #5, #6, #7, #9, #15, #18, #20, #23. 11/01/09	

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F 272	Continued From page 5 assessment documentation should generally describe: Nature of the condition...; complications and risk factors that affect the staff's decision to proceed with care planning; factors that must be considered in developing individualized care plan interventions...; need for referrals or further evaluation by appropriate health professionals." Review of section V of the RAI for 10 of 10 sample residents revealed the location of assessment information referred to for all triggered areas except activities and nutrition were not comprehensive assessments. Rather, the information referred to were data collection tools, such as the MDS Data Collection Tool, the medication administration records, and daily care records. Specifically, there were no comprehensive assessments for the following: a. The areas of activities of daily living (ADLs), falls, and psychotropic drugs for the 3/27/09 annual RAI for resident #1. b. The areas of cognition, vision, communication, ADLs, urinary incontinence, behaviors, falls, dehydration, pressure ulcers, and psychotropic drugs for the 6/26/09 annual RAI for resident #6. c. The areas of cognition, vision, communication, behaviors, ADLs, falls, dehydration, pressure ulcers, and psychotropic drugs for the 3/6/09 annual RAI for resident #7. d. The areas of communication, ADLs, urinary incontinence, falls, dehydration, pressure ulcers and psychotropic drugs for the 9/4/09 significant change RAI for resident #9. e. The areas of delirium, cognition, communication, ADLs, urinary incontinence, psychosocial well-being, mood, behaviors, falls, dehydration, and psychotropic drugs for the 8/28/09 significant change RAI for resident #23.	F 272	8) This will be reported at the monthly QA/QI meeting and at the monthly medical director meeting	11/01/09

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F 272	Continued From page 6 f. The areas of cognitive loss, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, falls, dehydration/fluid maintenance, dental care, and psychotropic drug use for the 8/21/09 admission RAI for resident #4. g. The areas of visual function, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, dehydration/fluid maintenance, dental care, pressure ulcers, and psychotropic drug use for the 12/19/08 annual RAI for resident #5. h. The areas of cognitive loss, visual function, communication, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, dehydration/fluid maintenance, pressure ulcers, and psychotropic drug use for the 1/9/09 annual RAI for resident #15. i. The areas of cognitive loss, visual function, communication, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, mood state, falls, dehydration/fluid maintenance, and psychotropic drug use for the 12/13/09 annual RAI for resident #18. j. The areas of cognitive loss, communication, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, dehydration/fluid maintenance, pressure ulcers, and psychotropic drug use for the 6/12/09 annual RAI for resident #20. During an interview on 9/16/09 at 3:15 PM, the MDS coordinator stated she used to do RAP summaries, but because she had to work the floor, she didn't have time to complete them. She acknowledged that there were not comprehensive assessments for the aforementioned areas.	F 272		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS	F 281		

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F 281	Continued From page 7 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure professional standards were followed related to nursing documentation for one of ten sample residents (#23). In addition, the facility failed to ensure professional standards were followed concerning medication administration for two of nine sample residents (#4, #15). The findings were: 1. Review of the closed medical record for resident #23 showed a physician note dated 9/2/09 at 7:36 PM which indicated nursing staff had notified him the resident had expired. However, review of nursing notes showed no documentation regarding the resident's expiration. The last nursing note was dated 9/1/09. During an interview on 9/16/09 at 1:50 PM, clinical supervisor #1 stated she was unable to find any nursing documentation from 9/2/09, and would call the nurse who worked that day. At 2:40 PM, she stated she spoke with the nurse. She stated the nurse told her she was unable to locate the medical record, therefore she did not document the time period surrounding the resident's death. On 9/16/09 at 2:50 PM, clinical supervisor #1 stated her expectation was that the nurse should have called her, to help locate the medical record, or should have documented on a blank nursing note. According to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, (page 40) "...Legally, care that is not recorded is considered care that was not provided. It is necessary	F 281	The facility will ensure that the services provided by or arranged by the facility will meet professional standards of quality. 1) The clinical supervisor will monitor,on a monthly basis, that care of residents is properly documented in the chart. 11/01/09 2) Charge nurses were instructed to chart care of residents, provider rounds and visits. This instruction took place at staff meeting on 09/30/09. 3) A quality monitoring tool will be implemented to ensure care is documented properly. 11/01/09 4) This will be reported at the QA/QI monthly meeting and at the medical director meeting monthly. 11/01/09 5) The clinical supervisor will observe medication pass to ensure the nurses don't touch medications with their hands. 11/01/09 6) Nurses were instructed not to touch medications with their hands at the staff meeting held on 09/30/09 7) A quality monitoring tool will be implemented to ensure nurses don't touch medications with their hands. This will be reported in the monthly QA/QI meeting and the monthly medical director meeting.	11/01/09

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F 281	Continued From page 8 therefore to chart all care that you do provide, as well as any care that you do not provide." 2. During observation of medication administration on 9/15/09 at 8:45 AM, registered nurse (RN) #1 removed 3 pills for resident #4 and 10 pills for resident #15 from bubble packs, placed them in her hand, then placed them into medication cups before administering the medications to the two residents. Interview with RN #1 on 9/15/09 at 9:30 AM showed she considered touching resident medications with bare hands to be inappropriate for medication administration. According to the 3rd edition of "Nursing Interventions & Clinical Skill" by Elkin, Perry, and Potter, when preparing medication, "Do not touch medication with fingers."	F 281		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care in accordance with the written plan of care for 1 of 9 sample residents (#6). The findings were: Refer to F315 for details regarding the facility's failure to provide toileting assistance per the care plan for resident #6.	F 282	The facility will ensure the services provided by or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 1) The charge nurse will observe that the CNA's are following the care plan for resident #6 by ensuring the resident is toileted every two hours. 11/01/09 2) CNA's were instructed to toilet residents according to their care plan at the staff meeting held on 09/30/09. 3) A quality monitor will be implemented to ensure that residents are toileted according to care plan. This will be reported at the monthly QA/QI meeting and at the monthly medical director meeting.	11/01/09
F 286 SS=C	483.20(d) RESIDENT ASSESSMENT - USE	F 286		

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F 286	Continued From page 9 A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain 15 months of Minimum Data Set (MDS) assessment information in the active medical record or easily retrievable for 10 of 10 sample residents (#1, #4, #5, #6, #7, #9, #15, #18, #20, #23). The findings were: Review of the medical record and MDS assessment books at the nursing station revealed the following assessments were missing, and were not easily retrievable: a. The 6/26/09 MDS assessment for resident #1. b. An 8/21/09 admission MDS assessment for resident #4. c. A 6/12/09 quarterly MDS assessment for resident #5. d. The 1/2/09 and 6/26/09 MDS assessments for resident #6. e. The 6/12/09 MDS assessment for resident #7. f. The 6/5/09 and 9/4/09 MDS assessments for resident #9. g. A 7/13/09 quarterly MDS assessment for resident #15. h. A 7/31/09 quarterly MDS assessment for resident #18. i. A 6/12/09 annual MDS assessment for resident #20. j. The 3/13/09, 6/9/09 and 8/28/09 MDS assessments for resident #23.	F 286	The facility will maintain all resident assessments completed within the previous 15 months in the resident's active record. 1) The Director of Operations will counsel with MDS Coordinator regarding timely completion of and maintenance of 15 months of resident assessments. 11/01/09 2) The MDS Coordinator has completed 15 months of MDS assesssments & are in the active medical record for residents #1, #4, #5, #6, #7, #9, #15, #18, #20, #23. 10/04/09 3) The Director of Operations will monitor MDS binders on a monthly basis to assure the previous 15 months are in place. 11/01/09 4) A quality monitoring tool will be implemented to ensure that assessments will stay in the medical record. This will be reported at the monthly QA/QI meeting and at the monthly medical director meeting.	11/01/09

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F 286	Continued From page 10 During an interview on 9/15/09 at 11:45 AM, the MDS coordinator stated the missing MDS assessments were "probably on my desk," or stated she would have to print them off. During an interview on 9/16/09 at 4:35 PM, the administrator and director of operations stated they were aware there was a problem with assessments not being kept in the active record.	F 286		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide services to promote bladder continence for 2 of 4 sample residents (#6, #18) who were incontinent of bladder. The findings were: 1. Review of the 6/26/09 Minimum Data Set (MDS) assessment revealed resident #6 was frequently incontinent of bladder. Review of the current care plan (care conference date of 7/9/09) showed staff were instructed to "prompt to toilet" every two hours, and toilet after meals. Observation on 9/15/09 from 7:55 AM until 2:10 PM revealed staff did not prompt or assist the	F 315	The facility will ensure that residents who enter the facility without an indwelling catheter will not be catheterized unless the resident's clinical condition demonstrates catheterization was necessary; and the resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 1) The charge nurse will observe that residents #6 and #18 will be toileted or prompted to toilet every 2 hours according to their care plan. 11/01/09 2) CNA's were instructed to toilet residents according to their care plan at the staff meeting held on 09/30/09. 3) A quality monitoring tool will be implemented to ensure residents #6 and #18 are toileted according to their care plan. This will be reported at the monthly QA/QI meeting and at the monthly medical director meeting.	11/01/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A051	A. BUILDING _____ B. WING _____	09/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

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F 315	Continued From page 11 resident to the toilet. Continuous observation on 9/15/09 at 2:15 PM showed s/he was being toileted by certified nurse aide (CNA) #1. The resident had an intense odor of urine at that time. The observation showed the resident was saturated with urine which included the resident's incontinence brief, pants, and wheelchair. On 9/15/09 at 3:40 PM, CNA #1 stated staff were instructed to take the resident to the toilet every two hours. 2. Review of the 7/31/09 quarterly MDS assessment for resident #18 showed s/he was frequently incontinent (daily with some control) of urine. Review of the care plan showed the resident was to receive assistance with activities of daily living that included toileting assistance and incontinence care, but no timeframe was given. Observation on 9/16/09 from 9:10 AM until 12:40 PM (3 hours and 30 minutes) showed the resident was not toileted. Observation on 9/16/09 at 12:40 PM showed the resident was being toileted by CNA #2. The resident had a noticeable odor of urine at that time. Further observation showed the resident was saturated with urine which included the resident's incontinence brief, pants, and wheelchair. During an interview with CNA #2 on 9/16/09 at 12:45 PM she stated the resident should have been toileted "at least every two hours."	F 315		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	The facility will ensure that the resident's environment is as free of accident hazards as is possible; each resident will receive adequate supervision and assistance devices to prevent accidents. 1) The clinical supervisors will walk through the facility each week and observe for accident hazards. If any are noted,	

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F 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure optimal Wanderguard operations for five residents (#4, #6, #14, #17, #22) using the Wanderguard safety system at one of five exits. The findings were: Periodic observations from 9/14/09 through 9/16/09 revealed a Wanderguard detector located at the living room facility exit was not firmly attached to the wall. The drywall screws attaching the Wanderguard to the wall had been pulled away from the wall and the detector had been reattached with surgical tape. Interview with staff maintenance on 9/15/09 at 11:50 AM revealed the Wanderguard needed to be reattached firmly to the wall in order to prevent it from being completely pulled off the wall and rendering the Wanderguard system non operational. A list provided by the facility revealed the following residents currently wore a Wanderguard bracelet: #14, #17, #22, #6, and #4.	F 323	maintenance will be notified immediately to make necessary repairs. 11/01/09 2) Maintenance will have the wanderguard detector repaired and firmly attached to the wall. 10/07/09 3) A quality monitoring tool will be developed to ensure that the wanderguard detectors are firmly attached to the wall and operating properly. 4) This will be reported at the monthly QA/QI meeting and at the monthly medical director meeting.	11/01/09
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a kitchen appliance was maintained in a safe manner. The findings were: Random observations during the survey revealed	F 465	The facility will provide a safe, functional, sanitary and comfortable environment for residents, staff and public. ~~1) SLNC would like to request an extension of time to complete tag F465 regarding the leak under the dishwashing machine found during the survey of 09/16/09.~~ Due to the age of the dishwashing machine gaskets are no longer available for its repair. The dishwasher will be replaced on February 15, 2010.	delete jc

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F 465	Continued From page 13 a three gallon plastic basin was sitting on the floor directly beneath the dish machine. The container was collecting water leaking from the machine. Interview with the kitchen manager on 9/16/09 at 9:48 AM revealed the gaskets on the machine were getting old and leaking, and the machine had been that way for over a year. The manager also stated that due to the location of the basin, when staff was operating the machine, they would occasionally inadvertently kick the basin and spill water on the floor creating a slip hazard.	F 465	2) The three gallon plastic basin will be emptied each time dishes are completed during the interim period, to keep the area free of standing water. 11/01/09 3) Dietary Manager will monitor daily for standing water in the three gallon plastic basin. If standing water is noted, the dietary manager will immediately instruct staff to empty the basin. 11/01/09 4) A quality monitor will be implemented to ensure there will be no standing water in the basin under the dishwasher. 11/01/09 5) This will be reported at the monthly QA/QI meeting and at the monthly medical director meeting.	11/1/09 ~~02/15/10~~
F 468 SS=D	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to securely attach resident handrails in two locations. The findings were: Periodic observations from 9/14/09 at 3:48 PM through 9/16/09 at 2:13 PM revealed two wall attachment points for the hallway handrails were coming away from the wall by resident room #102, and by the restroom opposite resident room #104. As a result, the handrails were unstable. Interview with the facility maintenance worker on 9/15/09 at 11:48 AM revealed he was unaware the rails were loose and coming away from the wall.	F 468	The facility will equip corridors with firmly secured handrails on each side. 1) Clinical supervisors will check corridor handrails weekly to ensure firm attachment. If any loose hand rails are noted, maintenance will be notified immediately so repairs can be made. 11/01/09 2) Maintenance repaired the handrails by resident room #102 and the handrail by the restroom opposite room #104. 10/07/09 3) A quality monitoring tool will be implemented to ensure all handrails in the corridor are firmly attached. 11/01/09 4) This will be reported at the monthly QA/QI and medical director meeting.	11/01/09